STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX
Petitioner

v **File No. 122355-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _7th___ day of December 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On July 14, 2011, XXXXX, personal representative of the estate of XXXXX[1] (Petitioner), filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on July 21, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information it used to make its adverse determination. The Commissioner received BCBSM's response on August 1, 2011.

The Petitioner is enrolled for health coverage through an underwritten group. The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

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1 Now deceased.

II. FACTUAL BACKGROUND

On November 29, 2010, the Petitioner was transferred by an air ambulance from XXXXX Hospital in XXXXX, Michigan, to the XXXXX Clinic. XXXXX Helicopters, LLC, charged $31,850.00 for the transport and BCBSM paid $12,016.89. XXXXX does not participate with BCBSM.

The Petitioner appealed BCBSM's payment amount through its internal grievance process. BCBSM held a managerial-level conference, and issued a final adverse determination dated June 28, 2011.

III. ISSUE

Is BCBSM required to cover an additional amount for the Petitioner's air ambulance service?

IV. ANALYSIS

Petitioner's Argument

In the request for external review, the Petitioner's personal representative wrote:

> After [the Petitioner] passed away I received a bill from XXXXX Helicopter for $19,833.11. The original bill was $31,850.00 of which BCBSM only paid $12,016.89, the balance of $19,833.11 was not covered due to XXXXX not being a participating service.
>
> I have been told that this helicopter was requested because of the specialized treatment needed due to the type of ventilator that [the Petitioner] was on.
>
> I was unaware of anything regarding the transport other than originally being told that the XXXXX helicopter was transporting him. I am unsure when the decision was made to switch the helicopter services.
>
> . . . I am hoping that BCBSM would reconsider the decision to deny the balance of the payment.

The Petitioner's personal representative states the balance she is being asked to pay would cause her great financial hardship now that her husband has passed away. She believes that BCBSM should pay substantially more for this service.

BCBSM's Argument

In "Section 5: Coverage for Other Health Care Services," the certificate states:

Professional Ambulance Services

We pay our approved amount for ambulance services. . . .

"Approved amount" is defined in Section 7 of the certificate (p. 7.2):

> The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

BCBSM indicates the certificate does not guarantee that a provider's charge will be paid in full. Rather, BCBSM's payment is based on the lesser of the provider's charge or BCBSM's maximum payment level – its approved amount. BCBSM states that it paid 100% of its approved amount to the Petitioner for the air ambulance transport, i.e., it reimbursed the Petitioner the same amount for the services as it would have paid to the ambulance service if it had been a participating provider.

BCBSM states that the reimbursement for the air transport was in accordance with the terms of the certificate and it is not required to pay any additional amount.

Commissioner's Review

The certificate explains that BCBSM pays an "approved amount" for ambulance service. There is nothing in the certificate that requires BCBSM to pay more than its approved amount, even in an emergency or even if there are no participating providers available. The certificate also does not require BCBSM to pay a nonparticipating provider's charge in full under any circumstances.

There is no difference in the amount BCBSM pays to participating and non-participating providers. However, participating providers have entered into an agreement with BCBSM which requires them to accept BCBSM's approved amount as payment in full for the covered service. In contrast, nonparticipating providers, like the air ambulance service in this case, have not agreed to accept BCBSM's approved amount as payment in full and may bill for any balance over the approved amount.

The certificate (p. 4.33) contains the following notice regarding nonparticipating providers:

> If the nonpanel provider is nonparticipating, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **Note**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM paid its approved amount for the Petitioner's air ambulance care as required by the certificate language. Nothing in the certificate requires BCBSM to pay more for the Petitioner's ambulance service, even, as in the case here, the service was provided on an emergency basis.

The Commissioner finds that BCBSM correctly applied the provisions of the Petitioner's certificate.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of June 28, 2011, is upheld. BCBSM is not required to provide any additional reimbursement for the Petitioner's air ambulance care.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner